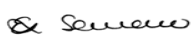
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. University Hospital of Derby and Burton; 2. NHS England; 3. Chief Coroner; and 4. Family of the deceased.
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the Derby and Derbyshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 19th February 2020, I commenced an investigation into the death of Mr Edward Cowey. The investigation concluded at the end of the inquest on the 1 October 2020. The conclusion of the inquest was one of accident stating: *"On the 28 January 2020 at the Royal Derby Hospital due to a subdural haematoma. This was caused when he fell whilst walking to the toilet of the Medical Assessment Unit of the Royal derby Hospital on the 23 January 2020".* The cause of death was: 1a) Subdural haematoma; II) Anticoagulation.
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Cowey was admitted to the Royal Derby Hospital on the 22 January 2020. He was admitted to the Medical Assessment Unit ("MAU"). On admission, he was given low molecular weight heparin (40mg), to prevent clotting. Given is past medical history, the dose should have been 20mg. This increased his chance of a bleed. ii) Whilst being treated on this ward, he had two falls. The second at 03:38 on the 23 January 2020 where Mr Cowey suffered a head injury. Neurological observations, in accordance with Trust and NICE Guidelines, were implemented. It was deemed he would not have a CT scan of the head. This was in contravention of the Trusts local Guidelines but not in contravention of NICE guidelines. iii) After each fall the necessary falls form was completed but not filed correctly within Mr Coweys' hard copy notes.

	iv) Mr Cowey was transferred to ward 310 at 12:30 on the 23 January 2020. The information regarding the falls and necessity to carry out neurological examination were recorded on the patient electronic notes, but not seen by the receiving ward. This was due to the fact that notes relevant to the patient were kept in different places, Extra Med, Patient Track and hard copy notes. Extra Med is a live database, to be updated at any time, and ward 301 had printed the ward transfer material pertaining to Mr Cowey before it was completed updated. Patient Track is difficult to navigate and the relevant information had to be searched for rather than being available "at a glance." v) Mr Cowey suffered with some numbness to his hands. He was examined by doctors on ward 310 on the 23 January 2020 at 16:13 and on the 24th January 2020 at 10:30. The examining doctors were not aware of the history of falls and therefore a CT head scan was not requested. Had his history been known, one would have been ordered. vi) On the 25 January 2020 it was noted that the low molecular weight heparin had been given at the wrong dosage and was stopped. Mr Coweys' medical condition deteriorated, and a CT scan of the head was requested. Mr Coweys scan showed a subdural haematoma that was not for medical intervention. After the results of the scan were obtained, the falls forms were located within Mr Coweys', hard copy notes. vii) Mr Cowey passed away on the 28 January 2020
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Evidence emerged during the inquest 1. That patient electronic and paper based transfer information is not kept on one database. Mr Coweys' handover notes were kept on extra Med, his neurological observations on Patient Track and the falls form on his hard copy notes; 2. Trust local policy regarding treatment for head injures is not consistent with NICE Guidelines and doctors cannot be expected to be aware of all trust local policies; 3. Anticoagulation guideless do not cover a situation where anticoagulation is being given as a preventative measure as opposed to a treatment; and 4. The Trusts local falls form does not direct doctors to the relevant guidance regarding head injuries simply asks if a CT head scans indicated
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. You may wish to consider the NHS policy and procedures for patient transfer, anticoagulation and head injury.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 December 2020. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to: 1. NHS England; 2. The Chef Coroner; 3. The University Hospital and derby and Burton; and 4. The family of the deceased. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**14 October 2020**  **Miss Emma Serrano** **Assistant Coroner** **Derby and Derbyshire Coroners Area**